General Assembly

Raised Bill No. 959

January Session, 2009

LCO No. **3399**

03399_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING EXTERNAL APPEALS OF ADVERSE DETERMINATIONS BY A MANAGED CARE ORGANIZATION, HEALTH INSURER OR UTILIZATION REVIEW COMPANY.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-478 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2009*):

As used in sections 38a-478 to 38a-478o, inclusive, as amended by this act, and subsection (a) of section 38a-478s:

(1) "Adverse determination" means a determination by a managed care organization, health insurer or utilization review company that an admission, service, procedure or extension of stay that is a covered benefit has been reviewed and, based upon the information provided, does not meet the managed care organization's, health insurer's or utilization review company's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and such requested, or payment for such, admission, service, procedure or extension of stay has been denied, reduced or terminated.

[(1)**]** (2) "Commissioner" means the Insurance Commissioner.

(3) "Covered benefit" or "benefit" means a health care service to which an enrollee is entitled under the terms of a health benefit plan.

(4) Except as provided in sections 38a-478m and 38a-478n, as amended by this act, "enrollee" means a person who has contracted for or who participates in a managed care plan for such person or such person's eligible dependents.

(5) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

[(2)**]** (6) "Managed care organization" means an insurer, health care center, hospital or medical service corporation or other organization delivering, issuing for delivery, renewing, **[**or**]** amending or continuing any individual or group health managed care plan in this state.

[(3)**]** (7) "Managed care plan" means a product offered by a managed care organization that provides for the financing or delivery of health care services to persons enrolled in the plan through: (A) Arrangements with selected providers to furnish health care services; (B) explicit standards for the selection of participating providers; (C) financial incentives for enrollees to use the participating providers and procedures provided for by the plan; or (D) arrangements that share risks with providers, provided the organization offering a plan described under subparagraph (A), (B), (C) or (D) of this subdivision is licensed by the Insurance Department pursuant to chapter 698, 698a or 700 and **[**that**]** the plan includes utilization review pursuant to sections 38a-226 to 38a-226d, inclusive, as amended by this act.

(8) "Preferred provider network" has the same meaning as provided in section 38a-479aa.

[(4)**]** (9) "Provider" or "health care provider" means a person licensed to provide health care services under chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

[(5) Except as provided in sections 38a-478m and 38a-478n, "enrollee" means a person who has contracted for or who participates in a managed care plan for himself or his eligible dependents.

(6) "Preferred provider network" means a preferred provider network, as defined in section 38a-479aa.**]**

[(7)**]** (10) "Utilization review" **[**means utilization review, as defined**]** has the same meaning as provided in section 38a-226.

[(8)**]** (11) "Utilization review company" **[**means a utilization review company, as defined**]** has the same meaning as provided in section 38a-226.

Sec. 2. Section 38a-478n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2009*):

(a) Any enrollee, or any provider acting on behalf of an enrollee with the enrollee's consent, who has exhausted the internal mechanisms provided by a managed care organization, health insurer or utilization review company to appeal the denial of a claim based on medical necessity or a determination not to certify an admission, service, procedure or extension of stay, regardless of whether such determination was made before, during or after the admission, service, procedure or extension of stay, may appeal such denial or determination to the commissioner. As used in this section and section 38a-478m, "health insurer" means any entity, other than a managed care organization **[**, which**]** that delivers, issues for delivery, renews, **[**or**]** amends or continues an individual or group health insurance plan in this state **[**, "health plan" means a plan of health insurance**]** providing coverage of the type specified in subdivision (1), (2), (4), (10), (11), (12) and (13) of section 38a-469, **[**but does not include a managed care plan offered by a managed care organization,**]** and "enrollee" means a person who has contracted for or who participates in coverage under an individual or group health insurance plan or a managed care plan **[**or health plan for himself or his**]** for such person

or person's eligible dependents.

(b) (1) To appeal a denial or determination pursuant to this section, an enrollee or any provider acting on behalf of an enrollee with the enrollee's consent shall, not later than sixty days after receiving final written notice of the denial or determination from the enrollee's managed care organization, health insurer or utilization review company, file a written request with the commissioner. The appeal shall be on forms prescribed by the commissioner and shall include the filing fee set forth in subdivision (2) of this subsection and a general release executed by the enrollee for all medical records pertinent to the appeal. The managed care organization, health insurer or utilization review company named in the appeal shall also pay to the commissioner the filing fee set forth in subdivision (2) of this subsection. If the Insurance Commissioner receives three or more appeals of denials or determinations by the same managed care organization or utilization review company with respect to the same procedural or diagnostic coding, the Insurance Commissioner may, on said commissioner's own motion, issue an order specifying how such managed care organization or utilization review company shall make determinations about such procedural or diagnostic coding.

(2) The filing fee shall be twenty-five dollars and shall be deposited in the Insurance Fund established in section 38a-52a. If the commissioner finds that an enrollee is indigent or unable to pay the fee, the commissioner shall waive the enrollee's fee. The commissioner shall refund any paid filing fee to (A) the managed care organization, health insurer or utilization review company if the appeal is not accepted for full review, or (B) the prevailing party upon completion of a full review pursuant to this section.

(3) Upon receipt of the appeal together with the executed release and appropriate fee, the commissioner shall assign the appeal for review to **[**an**]** a review entity, as defined in subsection **[**(c)**]** (g) of this section.

(4) Upon receipt of the request for appeal from the commissioner, the review entity conducting the appeal shall conduct a preliminary review of the appeal and accept the appeal if such review entity determines: (A) The individual was or is an enrollee of the managed care organization or health insurer; (B) the benefit or service that is the subject of the complaint or appeal reasonably appears to be a covered service, benefit or service under the agreement provided by contract to the enrollee; (C) the enrollee or provider acting on behalf of the enrollee with the enrollee's consent has exhausted all internal appeal mechanisms provided; (D) the enrollee or provider acting on behalf of the enrollee with the enrollee's consent has provided all information required by the commissioner to make a preliminary determination including the appeal form, a copy of the final decision of denial and a fully-executed release to obtain any necessary medical records from the managed care organization or health insurer and any other relevant provider.

(5) Upon completion of the preliminary review, the review entity **[**conducting such review**]** shall immediately notify the **[**member**]** enrollee or provider, as applicable, in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons why the appeal was not accepted for full review.

(6) If accepted for full review, (A) the review entity shall conduct such review in accordance with the regulations adopted by the commissioner, after consultation with the Commissioner of Public Health, in accordance with the provisions of chapter 54, and (B) the commissioner shall notify the managed care organization, health insurer or utilization review company of the receipt of a request for an external appeal and provide the name of the review entity assigned to such appeal. Not later than five business days after such notification, the managed care organization, health insurer or utilization review company shall provide to such review entity by electronic mail, telephone, facsimile or other expeditious method all documents and information that were considered in making the adverse determination

that is the subject of such appeal.

[(c) To provide for such appeal the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall engage impartial health entities to provide for medical review under the provisions of this section. Such review entities shall include (1) medical peer review organizations, (2) independent utilization review companies, provided any such organizations or companies are not related to or associated with any managed care organization or health insurer, and (3) nationally recognized health experts or institutions approved by the commissioner.**]**

[(d)**]** (c) (1) Not later than five business days after receiving a written request from the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, a managed care organization or health insurer whose enrollee is the subject of an appeal shall provide to the commissioner, enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, written verification of whether the enrollee's plan is fully insured, self-funded, or otherwise funded. If the plan is a fully insured plan or a self-insured governmental plan, the managed care organization or health insurer shall send: (A) Written certification to the commissioner or reviewing entity, as determined by the commissioner, that the benefit or service subject to the appeal is a covered benefit or service; (B) a copy of the entire policy or contract between the enrollee and the managed care organization or health insurer, except that with respect to a self-insured governmental plan, (i) the managed care organization or health insurer shall notify the plan sponsor, and (ii) the plan sponsor shall send, or require the managed care organization or health insurer to send, such copy; or (C) written certification that the policy or contract is accessible to the review entity electronically and clear and simple instructions on how to electronically access the policy or contract.

(2) Failure of the managed care organization or health insurer to

provide information or notify the plan sponsor in accordance with subdivision (1) of this subsection within said five-business-day period shall (A) create a presumption on the review entity, solely for purposes of accepting an appeal and conducting the review pursuant to subdivision (4) of subsection (b) of this section, that the benefit or service is a covered benefit under the applicable policy or contract, except that such presumption shall not be construed as creating or authorizing benefits or services in excess of those that are provided for in the enrollee's policy or contract, and (B) entitle the commissioner to require the managed care organization or health insurer from whom the enrollee is appealing a medical necessity determination to reimburse the department for the expenses related to the appeal, including, but not limited to, expenses incurred by the review entity.

[(e) The commissioner shall accept the decision of the review entity and the decision of the commissioner shall be binding.**]**

[(f)**]** (d) Not later than January 1, 2000, the Insurance Commissioner shall develop a comprehensive public education outreach program to educate health insurance consumers of the existence of the appeals procedure established in this section. The program shall maximize public information concerning the appeals procedure and shall include, but not be limited to: (1) The dissemination of information through mass media, interactive approaches and written materials; (2) involvement of community-based organizations in developing messages and in devising and implementing education strategies; and (3) periodic evaluations of the effectiveness of educational efforts. The Healthcare Advocate shall coordinate the outreach program and oversee the education process.

(e) (1) (A) Except as provided in subdivision (9) of this subsection, an enrollee or any provider acting on behalf of the enrollee with the enrollee's consent may make a request to the commissioner for an expedited external appeal at the time the enrollee receives an adverse determination if: (i) The time frame for completion of an expedited

internal appeal set forth in section 38a-226c, as amended by this act, may cause or exacerbate an emergency or life-threatening situation for the enrollee; and (ii) the enrollee or the provider acting on behalf of the enrollee with the enrollee's consent has filed a request for expedited review as set forth in section 38a-226c, as amended by this act.

(B) Upon receipt of such request and all required documentation, including the executed release and appropriate fee set forth in subsection (b) of this section, the commissioner shall immediately assign the appeal for review to a review entity.

(2) Upon receipt of the request for an expedited external appeal from the commissioner, the review entity shall, not later than two business days after receipt of such appeal, conduct a preliminary review of the appeal and accept the appeal for expedited review if such review entity determines: (A) The individual was or is an enrollee of the managed care organization or health insurer; (B) the benefit or service that is the subject of the appeal reasonably appears to be a covered service, benefit or service under the agreement provided by contract to the enrollee; (C) the enrollee or provider acting on behalf of the enrollee with the enrollee's consent has provided all information required by the commissioner to make a preliminary determination including the appeal form, a copy of the decision of denial and a fully-executed release to obtain any necessary medical records from the managed care organization or health insurer and any other relevant provider; and (D) the adverse determination may cause or exacerbate an emergency or life-threatening situation for the enrollee if not reviewed in an expedited time period.

(3) Upon completion of the preliminary review, the review entity shall immediately notify the enrollee or provider, as applicable, in writing as to whether the appeal has been accepted for full review and, if not so accepted, the reasons why the appeal was not accepted for full review.

(4) If accepted for full review, the review entity shall conduct such

review to determine whether the adverse determination should be reversed, revised or affirmed. Such review shall be performed by a provider who is a specialist in the field related to the condition that is the subject of the appeal. The review entity may take into consideration: (A) Pertinent medical records; (B) consulting reports from appropriate health care professionals and other documents submitted by the health insurer, the enrollee, the enrollee's authorized representative or the enrollee's provider; (C) practice guidelines developed by the federal government or national, state or local medical societies, boards or associations; and (D) clinical protocols or practice guidelines developed by the managed care organization, health insurer or utilization review company. For the purposes of this subparagraph, "authorized representative" means (i) a person to whom an enrollee has given express written consent to represent such enrollee in an external appeal, (ii) a person authorized by law to provide substituted consent for an enrollee, or (iii) a family member of the enrollee when such enrollee is unable to provide consent.

(5) To the extent the following information or documents are available and the review entity considers them appropriate, such review entity shall consider:

(A) The terms of coverage under the agreement provided by contract to the enrollee to ensure the review entity's decision is not contrary to the terms of coverage under such agreement;

(B) Medical or scientific evidence. For the purposes of this subparagraph, "medical or scientific evidence" means evidence found in the following sources:

(i) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(ii) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus (MEDLINE) or Elsevier Science for indexing in Excerpta Medica (EMBASE);

(iii) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the Social Security Act;

(iv) The following standard reference compendia: (I) The American Hospital Formulary Service - Drug Information; (II) Drug Facts and Comparisons; (III) the American Dental Association's Accepted Dental Therapeutics; and (IV) the United States Pharmacopoeia - Drug Information; and

(v) Findings, studies or research conducted by or under the auspices of federal government agencies or nationally recognized federal research institutes including (I) the Agency for Healthcare Research and Quality, (II) the National Institutes of Health, (III) the National Cancer Institute, (IV) the National Academy of Sciences, (V) the Centers for Medicare and Medicaid Services, (VI) the Food and Drug Administration, (VII) any national board recognized by the National Institutes of Health to evaluate the medical value of health care services, and (VIII) any other source that is comparable to those listed in subparagraphs (B)(v)(I) to (B)(v)(V), inclusive, of this subdivision;

(C) Any applicable clinical review criteria developed and used by the managed care organization, health insurer or utilization review company in making adverse determinations; and

(D) After considering subparagraphs (A) to (C), inclusive, of this subdivision, the opinion of the review entity's clinical reviewer or reviewers.

(6) The review entity shall complete its full review not later than

two business days after the completion of its preliminary review and shall forward its decision to reverse, revise or affirm the adverse determination together with its report of the full review to the commissioner. The review entity may request from the commissioner an extension of time to complete its review due to circumstances beyond its control. If an extension is granted, the review entity shall provide written notice to the enrollee or the enrollee's provider, setting forth the status of the review, the specific reasons for the delay and the anticipated date of completion of the review.

(7) In reaching a decision under subdivision (6) of this subsection, a review entity shall not be bound by any decisions or conclusions reached by the managed care organization, health insurer or utilization review company pursuant to section 38a-226c, as amended by this act, or this section.

(8) The commissioner shall notify the managed care organization, health insurer or utilization review company of the receipt of a request for an expedited external appeal and provide the name of the review entity assigned to such appeal. Not later than one business day after such notification, the managed care organization, health insurer or utilization review company shall provide to such review entity by electronic mail, telephone, facsimile or other expeditious method all documents and information that were considered in making the adverse determination that is the subject of such appeal.

(9) The commissioner shall not provide an expedited external appeal if the health care services that are the subject of the appeal have already been provided to the enrollee.

(10) If a request for an expedited external appeal is denied, an enrollee or any provider acting on behalf of the enrollee with the consent of the enrollee may submit such request for a standard external appeal as set forth in subsection (b) of this section.

(11) The commissioner shall assign review entities to appeals on a

random basis and shall choose such entities from among those approved by the Insurance Commissioner, after consultation with the Commissioner of Public Health, as set forth in subsection (g) of this section.

(f) (1) An external appeal decision shall be binding on the managed care organization, health insurer, utilization review company and enrollee. Nothing in this subdivision shall be construed to limit or prohibit any other remedy available under federal or state law.

(2) No enrollee or provider acting on behalf of the enrollee with the enrollee's consent shall file a subsequent request for external appeal involving the same adverse determination for which the enrollee has already received an external appeal pursuant to this section.

(g) (1) After consultation with the Commissioner of Public Health, the Insurance Commissioner shall engage independent review entities to provide medical review under the provisions of this section. For the purposes of this section, "review entity" means an entity that conducts independent external reviews of adverse determinations. Such review entities include, but are not limited to, medical peer review organizations, independent utilization review companies, provided such organizations or companies are not related to or associated with any managed care organization or health insurer, and nationally recognized health experts or institutions approved by the Insurance Commissioner.

(2) (A) (i) To be eligible for approval by the commissioner, a review entity shall have received approval or accreditation by a nationally recognized private accrediting review entity approved by the commissioner, or shall demonstrate to the commissioner that such review entity adheres to qualifications that are substantially similar to, and do not provide less protection to enrollees than, those set forth in subsection (h) of this section.

(ii) A review entity that is accredited by a nationally recognized

private accrediting review entity that has independent review accreditation standards, which the commissioner has determined are equivalent to or exceed the minimum qualifications of subsection (h) of this section, shall be deemed to be eligible for approval by the commissioner.

(B) Each review entity shall provide a statement of qualifications to the commissioner in accordance with state and Insurance Department contracting requirements.

(3) Each approval shall be effective for two years, unless the commissioner determines before its expiration that the review entity is not satisfying the minimum qualifications set forth in subsection (h) of this section. If the commissioner determines that a review entity is not satisfying such minimum qualifications, the commissioner shall terminate the review entity's contract.

(h) (1) Each review entity approved by the commissioner pursuant to subsection (g) of this section shall have and maintain written policies and procedures that govern all aspects of the standard and expedited external appeal processes set forth in subsections (b) and (e) of this section, including, but not limited to:

(A) A quality assurance mechanism that ensures: (i) That external appeals are conducted within the time frames specified and required notices are provided in a timely manner; (ii) the selection and employment of qualified, impartial and sufficient number of clinical reviewers to conduct external appeals on behalf of the review entity and suitable matching of reviewers to specific cases; (iii) the confidentiality of medical and treatment records and clinical review criteria; and (iv) that any person employed by or under contract with the review entity complies with the provisions of this section.

(B) A toll-free facsimile service or electronic mail that is able to receive information related to external appeals on a twenty-four-hours-per-day, seven-days-per-week basis; and

(C) An agreement to maintain and provide to the commissioner the information required in subsection (j) of this section.

(2) Each clinical reviewer assigned by a review entity to conduct external appeals shall be a physician or other health care provider who meets the following minimum qualifications:

(A) Is an expert in the treatment of the enrollee's medical condition that is the subject of the external appeal;

(B) Is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition as the enrollee;

(C) Holds a nonrestricted license in a state of the United States and, for a physician, holds a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external appeal; and

(D) Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, taken or pending by any hospital, governmental agency or unit or regulatory body, that raise a substantial question as to the physical, mental or professional competence or moral character of such reviewer.

(3) In addition to the requirements set forth in subdivision (1) of this subsection, a review entity shall not own or control, be a subsidiary of or be owned or controlled by, or exercise control over a managed care organization, health insurer, utilization review company, health plan, a national, state or local trade association of managed care organizations or health insurers or a national, state or local trade association of health care providers.

(4) (A) Neither the review entity assigned by the commissioner to conduct an external appeal nor any clinical reviewer assigned by the review entity to conduct such appeal shall have a material professional, familial or financial conflict of interest with any of the

following:

(i) The managed care organization, health insurer or utilization review company that is the subject of the external appeal;

(ii) The enrollee whose treatment is the subject of the external appeal or the provider acting on behalf of the enrollee with the enrollee's consent;

(iii) Any officer, director or management employee of the managed care organization, health insurer or utilization review company that is the subject of the external appeal;

(iv) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external appeal;

(v) The facility at which the recommended health care service or treatment would be provided. For the purposes of this subparagraph, "facility" means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitative or other therapeutic health settings; or

(vi) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the enrollee whose treatment is the subject of the external appeal.

(B) When determining whether a review entity or clinical reviewer has a material professional, familial or financial conflict of interest, the commissioner shall take into consideration situations in which the review entity or clinical reviewer to be assigned to conduct an external appeal may have an apparent professional, familial or financial relationship or connection with a person described in subparagraph (A) of this subdivision but that the characteristics of such relationship

or connection are such that they do not constitute a material conflict of interest that disqualifies the review entity or clinical reviewer from being assigned to the specific case.

(5) A review entity shall be unbiased and shall establish and maintain written procedures to ensure such impartiality, in addition to any other procedures required to be maintained by this section.

(i) No review entity or clinical reviewer working on behalf of a review entity, or an employee, agent or contractor of a review entity shall be liable in damages to any person for any opinion rendered or act or omission performed within the scope of the review entity's or such employee's, agent's or contractor's duties during or upon completion of an external appeal conducted pursuant to this section, unless such opinion was rendered or act or omission was performed in bad faith or involved gross negligence.

(j) (1) Each review entity shall maintain written records for review by a managed care organization, health insurer or utilization review company on all requests for standard and expedited external appeals for which such entity conducted such reviews during a calendar year. The review entity shall retain such written records for at least six years.

(2) Each review entity shall submit a report to the commissioner upon request, in a format prescribed by the commissioner. Such report shall include, for each managed care organization, health insurer and utilization review company:

(A) The total number of requests for standard external appeals and the total number of requests for expedited external appeals;

(B) The number of standard external appeals and the number of expedited external appeals that were resolved, and of those resolved, the number reversing the adverse determination, the number revising the adverse determination and the number affirming the adverse determination;

(C) The length of time for resolution of each external appeal;

(D) A summary of the procedure and diagnosis codes for which an external appeal was sought; and

(E) Any other information the commissioner may require.

Sec. 3. Subdivision (2) of subsection (a) of section 38a-226c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2009*):

(2) Each utilization review company shall maintain and make available a written description of the appeal procedure by which either the enrollee or the provider of record may seek review of determinations not to certify an admission, service, procedure or extension of stay. An appeal by the provider of record shall be deemed to be made on behalf of the enrollee and with the consent of such enrollee if the admission, service, procedure or extension of stay has not yet been provided or if such determination not to certify creates a financial liability to the enrollee. The procedures for appeals shall include the following:

(A) Each utilization review company shall notify in writing the enrollee and provider of record of its determination on the appeal as soon as practical, but in no case later than thirty days after receiving the required documentation on the appeal.

(B) On appeal, all determinations not to certify an admission, service, procedure or extension of stay shall be made by a licensed practitioner of the healing arts.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2009*	38a-478
Sec. 2	*October 1, 2009*	38a-478n
Sec. 3	*October 1, 2009*	38a-226c(a)(2)

Statement of Purpose:

To provide expanded benefits to consumers while improving transparency, and contracting and performance oversight of third-party administrators.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]